Eurasian Coalition on Male Health

ECOM

MSM AND TRANS* COMMUNITY PARTICIPATION IN HIV DECISION-MAKING PROCESSES IN ARMENIA, BELARUS, GEORGIA, KYRGYZSTAN AND MACEDONIA

Baseline assessment commissioned by ECOM within the framework of the GFATM program "Right to Health"

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2018

Stuikyte R. & al. MSM and trans* community participation in HIV decision-making process in Armenia, Belarus, Georgia, Kyrgyzstan and Macedonia : Baseline assessment commissioned by ECOM within the framework of the GFATM program "Right to Health"/ **R. Stuikyte, D. Kamaldinov, K. Kepuladze, S. Chikhladze, M. Kasianczuk** (Eurasian Coalition on Male Health). – Tallinn, 2018. – 39 p.

Special thanks are extended to the respondents and experts from Armenia, Belarus, Georgia, Kyrgyzstan, and Macedonia, who provided information and without whom this survey could not have been accomplished.

The publication was prepared and published within the regional program "Right to Health", implemented by the Eurasian Coalition on Male Health (ECOM) with the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Contents

List of Abbreviations

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy for HIV
CCM	Country Coordinating Mechanism
CEECA	Central and Eastern Europe and Central Asia
CSO	Civil society organization
ECOM	Eurasian Coalition on Male Health
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHPP	Georgian HIV Prevention Project
HIV	Human immunodeficiency virus
IDU	Intravenous drug users
KP	Key Population
LGBT	Lesbian, Gay, Bisexual, and Transgender People
MoH	Ministry of Health
MSM	Men who have sex with men
NCDCPH	National Center for Disease Control and Public Health
NGO	Non-governmental organization
OSF	Open Society Foundation
PLH	Person or people living with HIV
PrEP	Pre-exposure prophylaxis
RFSU	Swedish Association for Sexual Education (Riksförbundet för sexuell upplysning)
SOGI	Sexual Orientation and Gender Identity
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
SW	Sex workers
TB	Tuberculosis
Trans*	Transgender
VCT	Voluntary counseling and testing (largely for HIV)

Background

Men who have sex with men (MSM) and transgender (trans*) people, particularly trans* women, are key populations (KP) at high risk for HIV infection. However, too often they are unable to contribute their expertise and share their experiences in country dialogue processes across Central and Eastern Europe and Central Asia (CEECA). In many cases, MSM and trans* people are excluded from Country Coordinating Mechanisms (CCMs), and other HIV governance processes. Even where MSM or trans* groups are represented, the actual extent of their influence remains low.[1]

While most national HIV/AIDS plans in CEECA recognize MSM as KP at higher risk for HIV infection, programs aimed at MSM are underfunded or not funded at all.[2] If funded, the majority, if not all, of their financing comes from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). As the GFATM withdraws from CEECA countries, the sustainability of even these few existing services is put at risk. The importance of human rights interventions as an effective component of the HIV response among MSM is also overlooked.[3] The trans* community has been completely omitted from national HIV/AIDS strategies and plans,4 either as a separate group or as a subgroup that may fall into other KP.

MSM and trans* people in CEECA face numerous structural and social barriers that prevent meaningful participation in country dialogue processes: discriminatory laws and practices, a lack of resources for community-based organizations, and a general lack of knowledge among MSM and trans* people about country dialogue processes.[5]

There is a difference between programs that are done for MSM and those led by MSM.[6] Programs that are done for MSM are likely to result in services that are viewed with apprehension and therefore underused. Programs done with or led by gay and other MSM are likely to result in earlier service engagement and improved retention in services, yielding better health outcomes. Initiatives led by MSM operate under the principle that MSM are best equipped to help each other learn to protect themselves from risks to their health and safety and from human rights violations. Therefore, MSM should be the driving force in targeted programs addressing HIV. It is not enough to consult with them before creating a program. Rather, programs should be based on their needs, perceptions and experiences.

Programs led by MSM have resulted in improved reach, access, service quality, service uptake, condom use, and engagement of MSM in national policies and programs. Scaling up comprehensive, community-based HIV services helps prevent significant numbers of new HIV infections, particularly in settings with high rates of HIV. Community empowerment is the cornerstone of a human rights based approach to HIV, and, as such, underpins all recommendations and components related to HIV programs.[7]

Although MSM face barriers in accessing low threshold prevention services and other health care services, trans* people face an even more dire situation. While extremely limited epidemiological data is available for the region, HIV prevalence as high as 27% has been documented amongst trans* sex workers (SW).[8] This echoes global experience that shows that trans* women worldwide have an HIV risk ratio of 48.8 compared with all adults of reproductive age (Policy Brief: Transgender People and HIV. WHO/HIV/2015.17). It should be noted that no country in Eastern Europe or on the continent of Africa had published HIV prevalence data on trans* women at the time of these studies. Despite this documented level of risk, trans* people remain excluded from HIV responses both in policy and in practice.

Trans*-specific HIV data is limited. The majority of published literature focuses on trans* women, given that the effect of HIV on this population is well documented. In general, health data, including HIV prevalence data, is less robust for trans* people than for the general population due to challenges in sampling, lack of population size estimates, and issues of stigma and discrimination. Research and surveillance data that include trans* people frequently fail to disaggregate the data by gender identity and involve sample sizes too small to make reasonable inferences. Trans* people remain severely underserved in the response to HIV, with only 39% of countries reporting in the National Commitment and Policy Instrument 2014 that their national AIDS strategies address trans* people.[9]

Trans* people can lead the process of community empowerment by engaging and mobilizing members of their community to develop solutions to their collective problems and to advocate for protection of their human rights. The meaningful participation of and partnerships with community-led organizations and networks in the planning, implementation, monitoring, and evaluation of activities is fundamental to improving HIV service provision for trans* people. HIV prevention, care, and treatment interventions are more effective and sustainable when conducted jointly with community empowerment efforts.

Empowered Lesbian, Gay, Bisexual and Transgender (LGBT) communities that are involved in HIV decision-making processes can be best positioned to reach their members, rally support, and lobby their respective governments to tailor national HIV responses to the needs of KP.

To address the many challenges related to the meaningful involvement and representation of LGBT and MSM communities in responses to the HIV epidemic, the Eurasian Coalition on Male Health (ECOM) initiated a three-year regional program, “Right to Health”, funded by the GFATM. The Regional Program focuses on 5 target countries: Armenia, Belarus, Georgia, Kyrgyzstan, and Macedonia. ECOM commissioned this baseline assessment at the beginning of the Regional Program in 2017. In 2019, this study will be repeated as a part of the final evaluation of ECOM’s Regional Program. Comparing the results with current data will help to evaluate the effectiveness of the Regional Program in each target country and at the regional level.

Executive Summary

MSM and trans* community participation in HIV decision-making processes was reviewed as part of a baseline assessment of 5 countries (Armenia, Belarus, Georgia, Kyrgyzstan and Macedonia) within the framework of ECOM's regional program "Right to Health" funded by the GFATM.

During the initial phase of the assessment, the survey protocol and both quantitative and qualitative assessment tools were developed. Each component of tool 1 was scored, aside from the first component, which is comprised solely of relevant socio-economic characteristics of the country. Each component was comprised of a set of questions: one component consists of 14 questions, the other 3 components consist of 7 questions (35 questions in total). Each question was scored using a three-point system ("0" = largely not true, not achieved; "1" = significant progress, but major gaps exist; "2" = largely true). Thus, each question could have a maximum score of 2 and a minimum score of 0. The maximum possible score that each country could receive was 70 (35 questions, 2 points per question). Below are the descriptions of each component and what main criteria/requirements each component must satisfy in order to receive the maximum score.

Level of community development, advocacy and partnerships:
There is a renewal and growth of community activism: New leaders/activists* in HIV prevention and LGBT health programming emerged among MSM and trans* communities, contributing to a diversity of representation in the last 2 years; Technical or other kinds of support for capacity development both in country and internationally is available and used by the new leaders; Active partnerships between community organizations exist; LGBT organizations have integrated the issues of HIV and the right to health into their work; LGBT, human rights and HIV service organizations jointly advocate for state funding for HIV services for MSM and trans* people, etc.

Level of institutionalization and quality control of HIV services for MSM and trans* people:
HIV epidemiological data (on prevalence, incidence, testing, condom use, etc.) for MSM and trans* people is available at the national level; Specialized community-based and medical services (pre-contact prevention, HIV testing and pre- and post-test counseling, sexually transmitted infection (STI) treatment, etc.) for MSM and trans* people exist, are institutionalized within the national health system and regulated by clinical protocols/operational procedures or by similar documents;

* Account for at least 20% of openly LGBT activists or leaders speaking out at relevant events or through media or social networks in their country.

Community members are involved in quality assurance of those services; Standards on MSM- and trans*-oriented HIV prevention services are developed and approved/accepted at the national level, etc.

Level of participation of MSM and trans* people in HIV governance, policy, and funding:

MSM and trans* people are directly represented, have a voting right, and are active (i.e. they propose agenda items, initiate discussions, etc.) in HIV coordinating bodies; Community representatives are elected to coordinating bodies by community members through a transparent, democratic, and documented procedure; Both MSM and trans* people are designated as KP in the national HIV program (or in other state health programs dealing with HIV); Elected representatives from MSM/LGBT organizations in HIV coordinating bodies communicate with the community on a regular basis (once per quarter) and gather community opinions (through face-to-face meetings, online consultations, online surveys, discussions on listservs, etc.).

Availability and level of application of government mechanisms for purchasing social and health services from NGOs working with MSM and LGBT communities:

There is legislation and an operational mechanism for distributing state funds to non-governmental organizations (NGOs) (including community-based organizations); HIV-service NGOs working with MSM and/or trans* people receive funding from national or local governments on a systematic basis and at a level sufficient for effective coverage of the target group (in the last two years); National HIV programs and/or transition plans for moving from international to national funding have established a plan to develop a mechanism for contracting services from NGOs, which include a pilot mechanism, and progress is being made towards the implementation of such plans.

Table 1 below shows the actual scores received by each country, as well as a comparison of these scores with the maximum possible score. Each component and its corresponding questions were scored based on documents, evidence, online resources, and commentary received from respondents and experts from the relevant countries. The consultants filled in the assessment tools accordingly and summarized the information. The detailed responses will be recorded and kept by ECOM. For external use, however, the answers will be integrated into the descriptive part of country profiles in a simplified form.

The results and conclusions were based on findings received from both tools (quantitative and qualitative). To assess the level and quality of MSM and trans* community participation, the following information was collected:

- Context of each project country: the gross socio-economic indicators (population, proportion of men, level of urbanization, migration, state spending on health, GDP, per capita income, poverty, access to the Internet, etc.);
- Development of the LGBT community: number of community groups; how many of these are officially registered; number of staff and volunteers of community groups; key approaches and advocacy issues; cooperation with other groups, academia, and with the business community; number of community members working on a voluntary basis;
- Cooperation among LGBT groups: consensus on advocacy strategies; do they have a strong unified voice; partnerships with other stakeholders and NGOs; is there a parliamentary group on LGBT issues;
- Situation regarding HIV and STI in general and among MSM and trans* populations (including testing and treatment cascade for MSM and trans* populations);
- Services for MSM and trans* people: mapping, service package and its epidemiological and economic feasibility; the level of quality regulation; institutionalization of service-related standards and methodologies in relevant documents; alignment with international standards and involvement of community in quality assurance; cooperation between NGOs and health facilities to serve MSM and trans* people;
- Inclusion of MSM and trans* people in national HIV/AIDS plans, coordination bodies and budgets: mechanism of involvement of community organizations in decision-making processes; community representation in decision-making bodies and their influence in decision-making processes; MSM and trans* dialogue with governments; community knows stakeholders and exerts some level of influence on them; interaction of community representatives with decision-makers;
- Public funding available for MSM or LGBT community NGOs to deliver services and for their core funding; economic effectiveness of services for MSM and trans* people.

Methodology used

The minimum sources of information required to complete the assessment were the following:

a) collection of key materials from key informants, ECOM, and through internet searches;
b) desk review;
c) two interviews with two experts per relevant country;
d) external views from at least 3-4 other stakeholders gathered through interviews or written requests via email or online surveys;
e) collection of any other information necessary to fill gaps via individual requests or emails;
f) verification of the results when relevant.

Desk review provided answers to a number of questions outlined in the country profile and the assessment tool concerning official and consensus data and regulations, such as HIV epidemiology, service levels and impact on behavior, as well as documents of national HIV programs and governance bodies.

Interviews were held with country representatives using guidelines designed and approved for this purpose. Skype interviews were held with governmental and community representatives in order to gather different perspectives and reduce the level of subjectivity. Additional requests for information were sent to individuals via email if interviews were not possible.

Following the completion of the assessment, **validation of the findings** was done by sending the draft document to the experts. The draft was prepared in English or Russian, depending on needs of local partners. In two cases, Belarus and Macedonia, the document was sent to only one representative each due to the sensitive information contained in the documents. In these countries, at least two experts consulted were also CCM members representing the interests of MSM, meaning that their work was directly assessed in the draft documents.

A final report for all countries was developed based on the final documents received from each country. Given the simplicity of the assessment, **no attempt was made** to receive **approval** from Ethics Committees of the relevant countries. The assessment was conducted during the period June 20—September 30, 2017. The tool first was piloted in Georgia (June 23—24, 2017).

Limitations of the assessment: The assessment process faced a number of limitations. For instance, the assessment was conducted by a team of 4 consultants based in different countries. Although they used a single assessment tool and strictly followed the protocol and instructions, a slight variation in approaches and in the interpretation of data from country to country may nevertheless exist. However, regular communication and exchange of data between

the consultants, coupled with support from ECOM, have minimized this risk. In addition, all consultants were actively involved in producing the final results and developing the current report. A second limitation of the assessment was the fact that, in most cases, it was not possible to make country visits to meet the stakeholders face-to-face during the assessment process. This was only done in Georgia where the assessment tool was piloted. Nevertheless, the consultants and country stakeholders maintained regular communication via e-mail, Skype and telephone calls.

Results and Discussion

The scoring results show that the involvement of MSM and trans* people in HIV decision-making processes ranges from 29% to 53% by country. This indicates that there is significant room for improvement in each component reviewed during the assessment, despite efforts made by international donor organizations or by countries themselves. Narrative details of the assessment are provided below.

Figure 1.

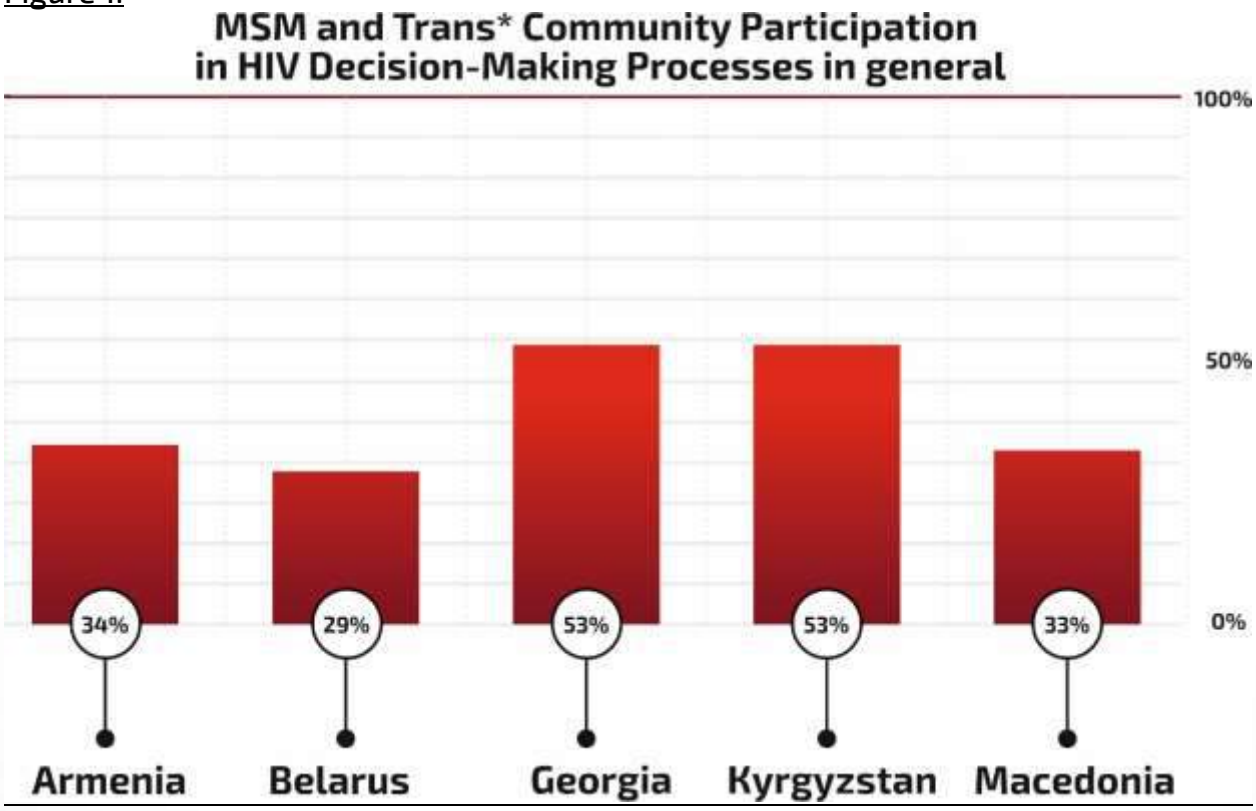


Table 1. Scoring by Country

Assessment Component	Armenia	Belarus	Georgia	Kyrgyzstan	Macedonia	Maximum possible score
Level of community development, advocacy and partnerships	**14**	**7**	**19**	**18**	**10**	**28**
Level of institutionalization and quality control of HIV services for MSM and trans* people	**2**	**3**	**4**	**2**	**3**	**14**
Level of participation of MSM and trans* people in HIV governance, policy, and funding	**4**	**5**	**8**	**11**	**4**	**14**
Availability and level of application of government mechanisms for purchasing social and health services from NGOs working with MSM and LGBT communities	**4**	**5**	**6**	**6**	**6**	**14**
Total Country Score	**24**	**20**	**37**	**37**	**23**	**70**
Percentage (actual score vs maximum score)	**34%**	**29%**	**53%**	**53%**	**33%**	**100%**

The scores for each component (Level of community development, advocacy, and partnerships; Level of institutionalization and quality control of HIV services for MSM and trans* people; Level of participation of MSM and trans* people in HIV governance, policy and funding; Availability and level of application of government mechanisms for purchasing social and health services from NGOs working with MSM and LGBT communities) are provided below, at the end of the narrative description of each component (See Figures 2-5).

Socio-Economic Development

The first component consists of data on the country's population, GDP, health expenditures as percentages of the government budget and of the GDP, rate of internet usage, etc. The country populations range from 2.07 million in Macedonia to 9.5 million in Belarus. The country with the highest GDP per capita is Belarus at 18,060.40 USD, and the lowest is Kyrgyzstan at 3,551.20 USD. As a percentage of the national budget, Belarus has the highest rate of health expenditures (13.8% of the state budget), while Armenia has the lowest rate (5.4%). Health expenditures comprise 4.5% of the GDP of Armenia and 7.9% of the GDP in Georgia, (i.e. there is a higher level of private sector and out-of-pocket expenditures in Georgia). More detailed data with references is available in Annex.

Level of Community Development, Advocacy and Partnerships

LGBT organizations exist and operate in all 5 countries. The number of LGBT community initiative groups and registered organizations varies from 4 (Macedonia) to 6 (Armenia). The number of openly LGBT or HIV+ activists participating in HIV and LGBT health advocacy at all levels varies from 2 (Kyrgyzstan) to 20 (Georgia). In all countries, there are very few new (joined in the past two years) openly trans* or HIV+ trans* activists participating in HIV prevention or LGBT health advocacy at any level, ranging from 0 in Macedonia to 2 in Georgia and Kyrgyzstan. In the 5 target countries, there is also a lack of new leaders from LGBT communities involved in HIV prevention or LGBT health advocacy, ranging from 2 in Belarus to 8 in Kyrgyzstan.[10]

Although there are a number of registered LGBT organizations and interest groups in the 5 target countries, not all of them are involved in HIV prevention activities or with the health sector in general. For example, out of the 6 organizations in Georgia, only 2 ("Identoba" and "Equality Movement") work on HIV and health issues. A similar situation exists in the other target countries. In countries such as Belarus, there are no legally registered LGBT rights organizations, due to unwritten political barriers and policies of law enforcement officials that prevent LGBT activists from registering their organizations. Only one de facto community organization, "Vstrecha", provides HIV prevention services to MSM and trans* people. 11 According to its statute, however, "Vstrecha's" mission is focused on the broader goal of advancing health, and is not focused on LGBT issues. This was done to avoid difficulties associated with the Belarusian government and its policies on LGBT issues. In Macedonia, there is also one community organization, "EGAL", that specializes in HIV services and that works exclusively with MSM. In Armenia, 4 community organizations work on HIV issues, however only two of them ("New Generation" and "PINK Armenia") indicate health and HIV as strategic priorities. In Kyrgyzstan, the community organizations, "Kyrgyz Indigo" and "Labris", provide HIV prevention services to the LGBT community.

Various initiative groups exist in the target countries along with officially registered community organizations. Some of these groups plan to attempt to officially register themselves (such as HelpTG in Belarus). Some initiative groups use online platforms to operate. It is worth mentioning that cooperation at the municipal level on intensive budget advocacy began in Tbilisi in 2017 under the project "City Platform for Sustainable and Efficient AIDS and Tuberculosis Interventions in Eastern Europe and Central Asia" implemented by the Alliance for Public Health (Ukraine) and funded by the GFATM. The creation of a city coordination council (City Task Force) is planned, in which all community organizations working on MSM issues will be represented. Along with these community organizations, the National Center for Disease Control

and Public Health (NCDCPH), CCM representatives, as well as service provider organizations will also be represented in the city coordination council.

All registered community organizations in the target countries have paid staff and volunteers. The number of staff and volunteers varies from country to country (from 11 volunteers in Macedonia to 96 volunteers in Armenia, and from 17 paid staff in Macedonia to 65 paid staff in Armenia). In Belarus, which has a total of 44 paid staff, it was difficult to identify how many staff members were representatives of the community.[12]

LGBT community organizations have established partnerships with each other, as well as with other organizations (both state and non-governmental). Macedonia serves as a good example of this, as different community organizations have formed a consortium/platform to facilitate communication between community representatives to better address HIV issues. Three community organizations working on HIV issues, EGAL (MSM group), Stronger Together (People living with HIV (PLH) group, whose membership and staff are more than more than 50% MSM), and STAR-STAR (SW group), have applied to coordinate their work with the implementation of ECOM's Regional Program for better involvement and representation of LGBT/MSM issues in the HIV response. Thus, the development of ECOM's Regional Program itself facilitated cooperation between EGAL, Stronger Together, and STAR-STAR. These three groups are a strong part of the NGO Platform for the Sustainability of HIV Prevention and Support Services, which is the main collaborative space for joint HIV advocacy by all HIV-service NGOs in the country. Stronger Together serves as the secretariat for the platform.

There are successful examples of cooperation between community and state organizations, such as the AIDS Center and the NCDCPH, in Georgia. Kyrgyzstan also serves as a successful example, as "Kyrgyz Indigo" has been working in cooperation with the Ministry of Internal Affairs on HIV issues since 2013. Armenian community organizations have also been cooperating with the National AIDS Center and other state structures for some time now. However, in Belarus, there is practically no direct cooperation between communities and state structures on advancing LGBT rights.

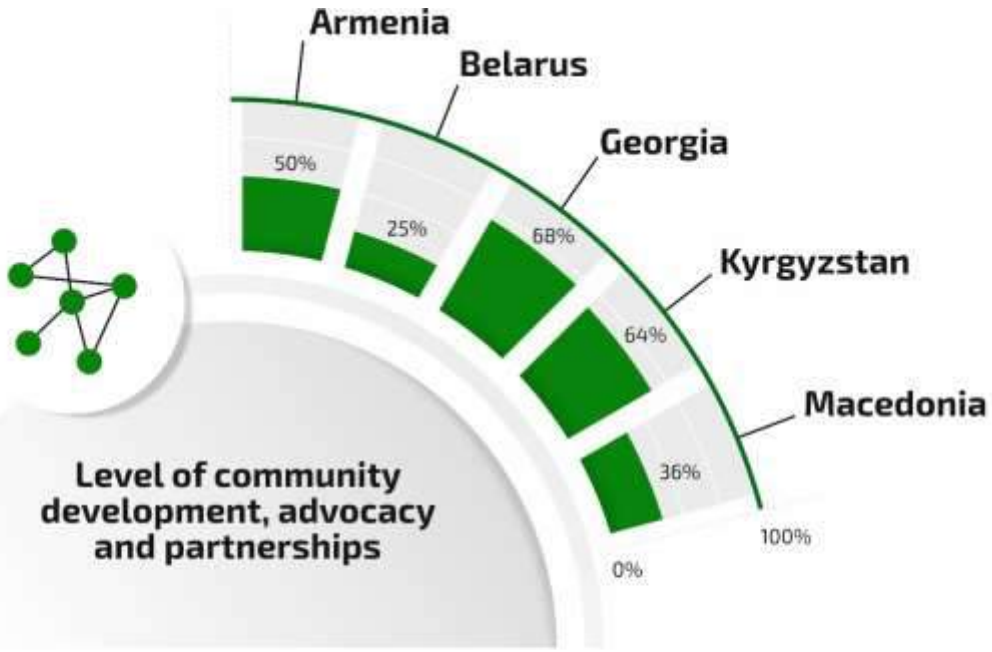
Good examples exist, in which LGBT community organizations and activists cooperate with other groups of KP. LGBT representatives are actively involved in drug policy liberalization in Georgia along with community organizations and activists representing intravenous drug users (IDU). LGBT community organizations working on health issues collaborate with human rights defender organizations in the majority of the target countries. The one exception is Belarus, where working on human rights issues and on LGBT rights is problematic or even dangerous due to state policies. Although "Vstrecha" does not have the ability to provide legal advice themselves, they are able to refer LGBT clients to a friendly lawyer when necessary. Interesting steps have been taken to strengthen the trans* community

in Belarus with the help of the leadership and support of the HIV NGO coalition, the Belarussian Anti-AIDS Network. As a result of their efforts, one trans* activist joined the CCM as an alternate member.

In the target countries, there are only a few instances of LGBT organizations collaborating with academic institutions. For instance, in Georgia, Ilia State University provides space and invites specialists to lecture on LGBT issues. In Kyrgyzstan, the American University of Central Asia also cooperates to a certain degree with the LGBT community by providing venues for lectures or discussions on HIV or LGBT issues. There is essentially no cooperation between LGBT organizations and the business sector in the target countries.

LGBT organizations and community groups are supported by donors, such as the GFATM, MSMGF, ECOM, COC Netherlands, Open Society Foundation (OSF), the Robert Carr Foundation, ILGA Europe, TGEU, embassies in relevant countries, etc.

Figure 2



100%: There is a renewal and growth of community activism: New leaders in HIV prevention and LGBT health programming emerged among MSM and trans* communities, contributing to a diversity of representation in the last two years; Technical or other kinds of support for capacity development both in country and internationally is available and used by the new leaders; Active partnerships between community organizations exist; LGBT organizations have integrated the issues of HIV and the right to health into their work; LGBT, human rights and HIV service organizations jointly advocate for state funding for HIV services for MSM and trans* people, etc.

Level of Institutionalization and Quality Control of HIV Services for MSM and Trans* People

Three of the target countries have concentrated epidemics, while the remaining two are considered as low HIV prevalence countries with a prevalence of less than 1% among the general population. However, HIV prevalence among MSM has been steadily increasing in recent years. In three of the target countries, HIV prevalence among MSM is above 5%: 5.7% in Belarus, 6.6% in Kyrgyzstan, with Georgia displaying the highest rate of HIV prevalence among MSM at 25.1% (IBBS 2015).13 Armenia and Macedonia are the two exceptions. Macedonia has been successful in keeping HIV prevalence among all KP under 5%, even among the most affected groups: MSM and male SW. In 2014, HIV prevalence among male SW was 3.43% and 1.9% among MSM,14 while only 0.05% among female SW and 0.123% among IDU. Data from Armenia is questionable. While there has been a steady increase in HIV prevalence among MSM in the whole region, data from the Armenian IBBS shows a decrease in HIV prevalence from 2012 to 2015 (2012 — 2.5%, 2014 — 0.4%, 2016 — 0.8%).[15]

IBBS studies show high levels of sexual activity among MSM. Risky sexual practices are quite widespread. MSM reported having high numbers of both male and female partners. Meanwhile, condom usage with both male and female partners is inconsistent, with rates that are already insufficient and, in some cases, decreasing. It was also reported that MSM engage in group sexual practices, often without the use of condoms. High risk sexual practices have not changed and, in some cases, have worsened over the last five years, for instance, in Georgia. These tendencies are reflected in the increase in HIV prevalence.

Population size estimations of MSM have been conducted in all 5 target countries. However, these studies were conducted with major limitations, and/or state and non-state stakeholders were not able to reach a consensus on population size estimates, such as in Armenia. Many stakeholders in all 5 countries have indicated that MSM population sizes are underestimated due to study limitations (i.e. sufficient sample size was not reached, study conducted only in the capital, bias in population census, etc.). Nevertheless, population size estimations remain essential in calculating the coverage of MSM with HIV prevention services and testing.

Table 2. MSM Population Size Estimations in 5 Target Countries[16 17 18 19 20]

Country	Estimated Size	MSM as % of Total Male Population (based on latest census)
Armenia	12,461 (2016)	0.9%
Belarus	60,000 (2015)	1.36%
Georgia	17,215 (2014)	1%
Kyrgyzstan	22,000 (2013)	0.75%
Macedonia	19,300 (2010)	1.86%

According to Belarusian sentinel data from 2015, 70.1% of MSM are covered with HIV prevention services and 64.5% with HIV testing services.[21] However, funding for HIV prevention services among MSM is limited. For example, "Vstrecha" can only provide STI diagnostics for 60 MSM per quarter. According to GFATM programmatic data, in Georgia in 2016, 3,826 MSM (unique individuals) received counseling services and informational materials on HIV/STI and reproductive health issues (90% of planned annual indicator), a further 2,035 MSM (unique individuals) received voluntary counseling and testing (VCT) and STI services (67% of planned annual indicator). In Macedonia in 2016, approximately 3,500-4,000 MSM were covered with the package of services including condoms, lubricants, and educational materials. According to Armenian IBBS data for 2016, HIV testing coverage of MSM was 51.2% in Yerevan, 22.5% in Gyumri, and 8.9% in Vanadzor. HIV prevention services coverage for MSM was 53.5% in Yerevan, 19.7% in Gyumri, and 69.8% in Vanadzor.22 According to sentinel data for 2016, coverage of MSM with HIV prevention services decreased significantly in Kyrgyzstan since 2013 (76.3% in 2013, compared with 37.8% in 2016).

Community organizations provide counseling, condoms, lubricants, informational and educational materials, peer education, and use elements of the Popular Opinion Leadership model. HIV rapid tests (including saliva tests in Armenia) are available in community-based organizations in Armenia, Georgia, and Macedonia. In Georgia, the biggest service-provision organization is Tanadgoma (a non-community organization, however its outreach workers working with MSM are recruited from the LGBT community).

There is insufficient data to generate the full HIV testing and treatment cascade for MSM in all 5 target countries. The largest potential gaps in the HIV testing and treatment cascade for MSM are low rates of HIV testing in general, and difficulties in confirming the results of those who have tested positive for HIV using rapid tests (this includes referrals to AIDS centers or other certified laboratories, which can run further diagnostics to confirm results).

In all the target countries, MSM are designated in national HIV/AIDS plans as KP with respect to HIV transmission, prevention and treatment.

The effectiveness and cost-effectiveness of MSM-targeted services have never been assessed in these countries. A partial assessment of the effectiveness and cost-effectiveness of MSM-targeted services was conducted in 2013 by the USAID-funded project Georgian HIV Prevention Project (GHPP). However, these results do not reflect the current situation, as the project was only a partial assessment and was conducted 4 years ago. Since then, the national currencies of the 5 target countries have all devaluated significantly. In addition, standards for prevention services packages for MSM and corresponding costing tools have not been approved by the governments of the 5 target countries. Some progress has been made in Georgia, where such standards and corresponding costing tool have been developed, however the Ministry of Health (MoH) has not yet approved these documents.

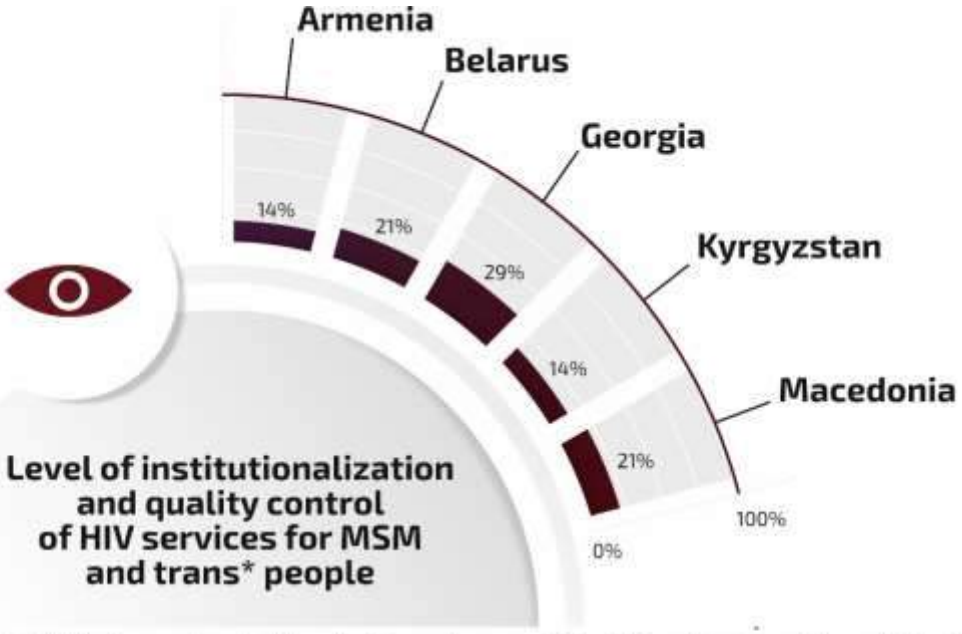
Community-based services for MSM are now fully funded by the GFATM. Ensuring sustainability and procuring national funding are top priorities for maintaining current services, as the GFATM plans to withdraw from these countries (Macedonia by the end of 2017, Georgia by 2021).

With respect to trans* populations, no data on population sizes or on HIV-related risks to the group exist. In addition, trans* health issues are not prioritized in national HIV policies, nor is there specific HIV programming for trans* people.

The sole exception is Kyrgyzstan, where trans* people are designated as a KP in the National HIV Plan for 2017—2021. The National Plan also indicates the approximate size of the trans* population (200 persons) based on programmatic data.

In 2017, the document "Guidelines on the Provision of Medical and Social Assistance to Trans* people" was published. The guide is designed to assist medical specialists at all levels of healthcare in Kyrgyzstan, and acts as the national standard for the provision of medical and social assistance. The guide was prepared by the Ministry of Health of the Kyrgyz Republic and the Republican Center for Mental Health, together with the City Endocrinology Dispensary and the State Medical Academy. In Belarus, an official commission for reviewing requests for sex reassignment procedures and endocrinological services for those persons exist. However, TransIT standards are not applied in the provision of such services.

Figure 3



100%: HIV epidemiological data (on prevalence, incidence, testing, condom use, etc.) for MSM and trans* people is available at the national level; Specialized community-based and medical services (pre-contact prevention, HIV testing and pre- and post-test counseling, sexually transmitted infection treatment, etc.) for MSM and trans* people exist, are institutionalized within the national health system and regulated by clinical protocols/operational procedures or by similar documents; Community members are involved in quality assurance of those services; Standards on MSM- and trans*-oriented HIV prevention services are developed and approved at the national level, etc.

Level of Participation of MSM and Trans* People in HIV Governance, Policy and Funding

In all 5 target countries, there are representatives of LGBT communities in national HIV structures. In Macedonia, there are two national bodies that deal with HIV issues: the National Coordination Mechanism on HIV and Tuberculosis (TB) (for GFATM grants), and the National Commission on HIV (less active that the National Coordination Mechanism, but with plans for reform). In both bodies, the LGBT/MSM community has one representative, both from an MSM service-provider organization. The MSM community has one representative in the CCM of Georgia. In Belarus, the CCM has one full member representing the LGBT community, as well as an alternate member from the trans* community. In addition, there is a CCM member who represents NGOs providing HIV prevention services to MSM, and who formerly represented all communities vulnerable to HIV. However, there is no CCM member representing MSM separately. In the CCM of Kyrgyzstan, there is one full member and one alternate member from the LGBT community. In Armenia, the LGBT community is represented in the CCM by a person representing the PLH community.

In most cases, the process of nominating and electing LGBT representatives to country coordination bodies is transparent and accessible by community members. In Macedonia and Belarus, there is a strong distinction between whether a CCM member is elected directly by communities or rather by NGOs. In Macedonia, NGOs elect representatives, and there are no separate seats chosen directly by communities. In Belarus, there are separate seats for both NGOs and community representatives, with separate voting processes as well. It is worth noting that Belarus was the first country in the CEECA region, in which a trans* person was elected as an alternate CCM member to represent the LGBT community. Respondents from Armenia noted that the CCM member representing the LGBT community was more involved with the PLH community than the LGBT community. LGBT community members from Georgia mentioned issues regarding effective communication between the CCM member representing the LGBT community and the general community itself. Although information is available upon request, there have been no regular updates regarding the CCM's activities and development. Respondents from Kyrgyzstan indicated that elections of the LGBT representative to the CCM are transparent.

In all target countries, MSM are mentioned in state documents (national HIV plans) as a KP with respect to HIV. The one exception is the Belarusian National Plan, which, in general, does not specify groups vulnerable to HIV and does not provide definitions, such as MSM, IDU, or SW. The following are the state documents or national plans on HIV: "Public Health and Demographic Safety of Belarus for 2016—2020";23 National HIV Plan for 2016—2018 in Georgia; National HIV/AIDS Plan for 2013—2016 in Armenia;[24] Kyrgyz National HIV Plan for 2017—2021. Macedonia

does not currently have a strategy in place. However, there is a national program for 2017 (in which MSM are mentioned), and MSM have been indicated as a priority group in the national strategy (and the GFATM grant) along with other KP during the past 5 years.

Trans* people are only indicated as a KP in the Kyrgyz National HIV Plan.

Some country plans, such as those of Georgia and Kyrgyzstan, set specific indicators for HIV prevalence among key groups, and HIV prevention and testing coverage levels for MSM for each year.25 The Belarusian State Sub-Program on HIV calls for increased coverage of vulnerable groups with prevention programs (without specifically mentioning MSM, trans* people, or any other group) from 26% in 2016 to 50% in 2020.

Countries have developed transition plans as the main donor, the GFATM, plans to withdraw from the region in the coming years. The CCM of Macedonia approved the country's transition plan in December 2016. However, the plan has not been approved by other government bodies, and is therefore not legally binding. The plan states that the funding for services provided by NGOs to key affected populations will be allocated from the national HIV programs for 2017 and 2018. Armenia's transition plan is being developed, however, concrete details are not currently known. Georgia's transition plan does a good job of highlighting the need to implement HIV prevention services and activities among MSM. The transition plan clearly indicates a gradual reduction of financial dependency on the GFTAM, and a gradual transition to state-funded programs. In addition, the plan calls for pre-exposure prophylaxis (PrEP) to be implemented among MSM, and mentions the need for additional surveys on its efficacy. In reality, PrEP implementation has already begun, as provided for in the National Strategic Plan for 2016-18, with the participation of community organizations, the AIDS Center, and the NCDCPH of Georgia. PrEP is also mentioned in a draft of the Macedonian national plan, but is still under consideration. The transition plan for Kyrgyzstan was also developed, and is expected to be approved as part of the new HIV strategy in 2017. The plan indicates the need to increase HIV treatment services, and to maintain funding levels for prevention services for MSM and trans* people to no less than 2014 levels (presently, funding is provided primarily by international donors).

To assess how incremental changes in spending affect HIV epidemics, and thereby determine the optimal funding levels, Optima studies were conducted in Armenia, Belarus, Georgia, Macedonia and Kyrgyzstan (2013-2015). Optima uses best-practice HIV epidemic modeling techniques and incorporates evidence on biological transmission probabilities, detailed infection progression, sexual mixing patterns and drug injection behaviors. Data relating to programs and costs associated with programs is used in an integrated analysis to determine an optimal distribution of funding under defined scenarios. The Optima model parameterizes relationships

between the cost of HIV intervention programs, the coverage level attained by these programs and the resulting outcomes. These relationships are specific to the country, population and program being considered.

The HIV Response Optima study in Macedonia was published in 2016, and provides the conclusion that MSM (and male SW) are projected to remain the main groups affected by HIV in the country in the future. The study recommended a substantial increase in the component for MSM prevention services (currently, the unit cost and overall expenses have been lower for MSM in comparison with other KP). The Optima study done in Kyrgyzstan was conducted in 2015 and was used in the development of the National HIV Plan and its targets. According to Optima, MSM programs should be expanded, but the unit cost should be decreased, as it is too high (449 USD) compared to relevant costs in other countries.

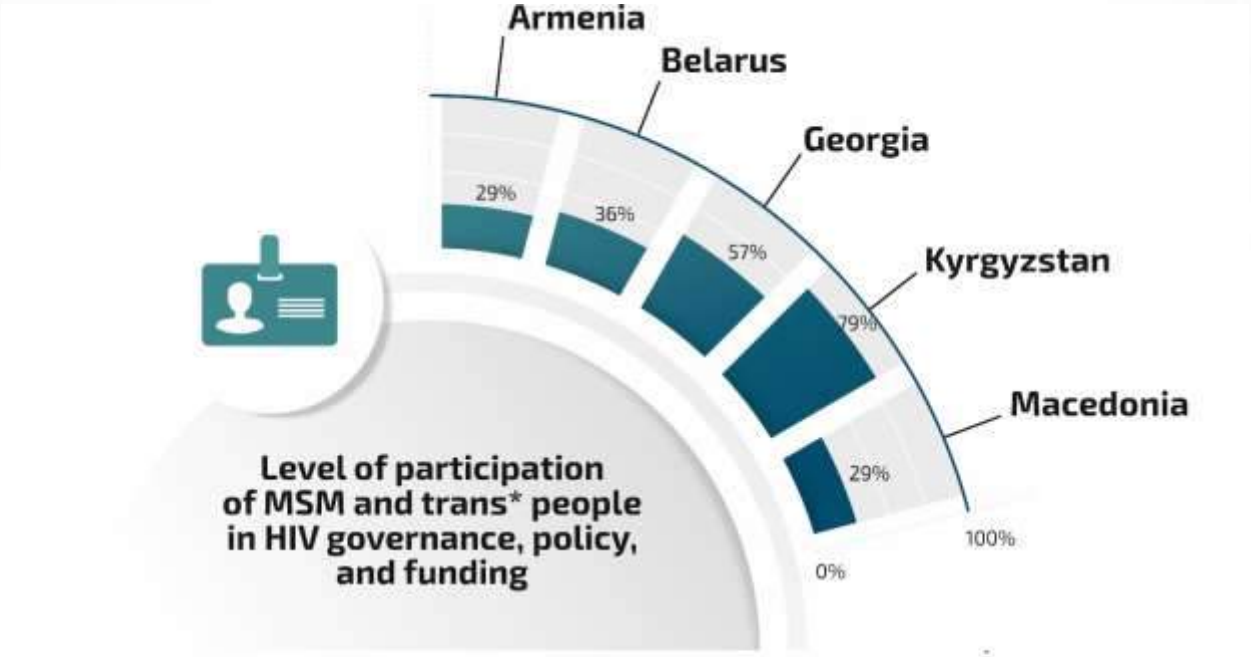
In Georgia, the Optima study was carried out in 2014, however the projection and results are no longer relevant, and do not correspond to the current situation (prevalence among MSM, etc.). However, the unit cost for MSM (according to Optima) covered by prevention services is 232.35 USD, which is higher than the corresponding cost for SW and IDU. In Belarus, according to Optima estimates (2013), MSM have become a rapidly growing segment of the epidemic, and, by 2030, are projected to account for 1 in 7 new HIV infections. According to the study, the unit cost is lowest in Belarus at 39.03 USD. In Armenia, according to Optima (2015), MSM programs should be continued with a focus on urban areas that have larger MSM populations and more regular epidemiological surveillance. The unit cost for MSM covered is 94.71 USD, and is less than the unit cost for SW or IDU. The unit cost for MSM covered by prevention programs in Macedonia is 48.96 USD, and is much less than the unit cost for SW or IDU. The historical data extracted by the Optima studies show a high variation of unit cost per MSM covered, and that, in some countries, the MSM component is significantly underfunded in comparison with other KP. It should be noted that some data from the Optima studies is already outdated and cannot be used to assess the current situation.

Table 3. Costing Data Extracted from Optima Studies[26 27 28 29 30] (2013—2015), USD

Country	Annual cost for MSM	Unit cost per MSM covered	Unit cost per IDU covered through needle exchange	Unit cost per SW covered
Armenia	235,000	94.71	129.27	107.05
Belarus	285,000	39.03	101.36	86.62
Georgia	403,818	232.35	64.75	166.30
Kyrgyzstan	595,999	449.13	116.38	103.65
Macedonia	134,733	49	174.5	203

The GFATM has been the sole donor for MSM services implemented by community NGOs or service-provision NGOs in the 5 target countries. However, it is difficult to compare country spending, as countries vary in terms of population number, MSM sizes, etc.

Figure 4



100%: MSM and trans* people are directly represented, have a voting right, and are active in HIV coordinating bodies; Community representatives are elected to coordinating bodies by community members through a transparent, democratic, and documented procedure; Both MSM and trans* people are designated as Key Populations in the national HIV program; Elected representatives from MSM/LGBT organizations in HIV coordinating bodies communicate with the community on a regular basis and gather community opinions

Availability and Level of Application of Government Mechanisms for Purchasing Social and Health Services from NGOs Working with MSM and LGBT Communities

In the 5 target countries, there are no official bans or legislative restrictions on the functioning of NGOs, although in some countries, community organizations may face difficulties. In Georgia, there is no legal barrier for state organizations to contract NGOs, however, there are rigid tendering procedures restricting the participation of financially weak organizations (e.g. a bank guarantee is required). These procedures may exclude certain NGOs from state tenders, primarily ones that are not financially or organizationally strong, such as community-based organizations, but which have valuable field experience in working with KP at the grassroots level. Moreover, in cases where the tender winner is selected based solely on financial criteria, there is a risk that the quality of services provided will decrease. There are a few cases, where the Georgian government has already granted funds to NGOs working in the field of mental health, or to organizations working with disabled people. However, no funds have been given to NGOs or communities for implementing HIV prevention services among KP (including MSM).

The Macedonian Law on Public Procurement allows for the procurement of services from NGOs on a competitive basis. In practice, the Ministry of Labor and Social Policy funds social services, however, its budget is smaller than the overall budget of HIV services implemented by NGOs. There are plans to establish a tailored social contracting mechanism for NGOs providing HIV services. By 2017, it is planned that the first real contracting of NGOs services will begin, however the procedure still needs to be clarified (probably using the Law on Public Procurement). In addition, in late autumn 2017, the National Program for 2018 (and its budget), as well as the multi-year strategy are expected to be approved. On September 5, 2017, the government adopted resolutions obligating the MoH "to allocate 103 million Macedonian denars [2 million USD] in the National HIV Program for 2018 for the purpose of providing continuous ARV treatment, as well as sustaining HIV prevention programs among key affected populations, in accordance with the expert estimations." This amount is nearly four times more than the amount that had been budgeted by the previous government for this year.

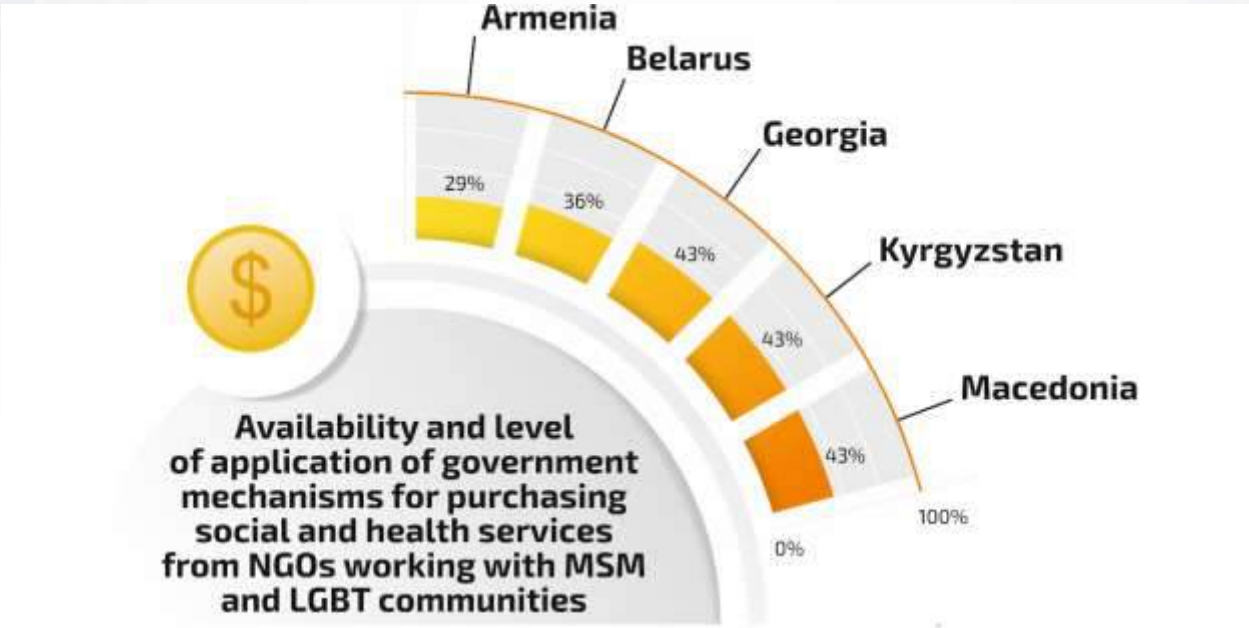
In Kyrgyzstan, there are also no legal or other barriers for purchasing services from NGOs. In 2017, a law on social contracting was approved, which will provide the possibility for different sectors, including the health sector, to fund NGO services. Currently, the MoH is convening a working group to develop a mechanism for selecting health priorities for social contracting, as well as for developing procedures for purchasing services and selecting service providers. This work is supported by USAID and is expected to be completed in 2018. However, no state

funds have yet been granted for the implementation of HIV prevention work among MSM, trans* people, or any other KP. In addition, the country is still facing difficulties in simply fully funding the provision of antiretroviral medication, let alone financing other HIV services. As yet, there has only been one example of an NGO obtaining state funds from the Ministry of Labor and Social Affairs to finance HIV interventions. These funds were used to implement prevention services among IDU on a small scale. NGOs have not received any funds from the MoH. A draft law that would prohibit "LGBT propaganda" has remained in the Kyrgyz Parliament for the last three years, with the continued risk that it will be formally adopted. The law, if adopted, would create serious obstacles for the functioning of all LGBT organizations and communities in the country.

Belarus is in the process of developing mechanisms for social contracting. In 2017, the laws on social services and on the prevention of dangerous diseases were amended to allow for the possibility of social contracting. The main normative acts to implement the new legislation are expected to be finalized and approved with participation from the LGBT community by the end of 2017. These laws provide opportunities for the state and local authorities to contract NGOs to provide HIV services.[31] The organizations represented in the CCM are actively advocating for the process and are closely cooperating with other HIV-service organizations. It is still unclear exactly what procedures and mechanisms will exist for social contracting. The national sub-program on HIV envisions the allocation of domestic funding for HIV prevention services for high risk groups starting in 2017, but in the absence of the social contracting mechanism, plans to replace GFATM funding have been postponed until 2018. It is important that funding should come from the local level. The Belarusian Anti-AIDS Network has led initial steps to engage with local authorities, and to raise issues related to MSM services in the course of this dialogue. These discussions have had some success in two regions, however, elsewhere, local coordinators from the NGO "Vstrecha" often do not want to engage with local authorities due to stigma. External respondents confirmed that harm reduction groups have been more active in this process, and that, in some cases, representatives of MSM organizations are unwilling to apply for state funding. The respondents highlighted the importance of local representatives being active in local health coordination mechanisms, using the political opportunities that the National Sub-Program on HIV provides, as well as support from other partners. If this process and advocacy work is successful, the first funding for HIV prevention among MSM from domestic resources in Belarus is expected in 2018.

In Armenia, there are no restrictions or bans regarding NGOs, however, there is no state policy or mechanism for social contracting. No state funds have been granted to LGBT organizations or to NGOs working on HIV prevention among MSM and trans* people. Some representatives of community organizations are strictly against receiving state funding, as they fear "getting involved in corruption deals" or that "community members would not trust the services".[32]

Figure 5



100%: There is legislation and an operational mechanism for distributing state funds to NGOs (including community-based organizations); HIV-service NGOs working with MSM and/or trans* people receive funding from national or local governments on a systematic basis and at a level sufficient for effective coverage of the target group (in the last two years); National HIV programs and/or transition plans for moving from international to national funding have established a plan to develop a mechanism for contracting services from NGOs, which include a pilot mechanism, and progress is being made towards the implementation of such plans

Conclusions

Level of Community Development, Advocacy and Partnerships

In each target country, several (4-6) LGBT organizations and community groups are officially registered and operating as LGBT community entities. The exception is Belarus, where LGBT organizations have failed to register as such due to the state's attitude towards LGBT issues and rights. Some registered organizations do not officially identify themselves as LGBT organizations, but are recognized by all stakeholders as LGBT community organizations. Meanwhile, other LGBT groups operate without registration.

Although various LGBT organizations exist in the target countries, health and HIV issues are not always priorities for all LGBT organizations. Among existing LGBT organizations, only 1-2 organizations (out of 4-6) provide HIV services to MSM and trans* people. The remaining community organizations focus on LGBT rights and monitoring violations of human rights based on sexual orientation and gender identity (SOGI).

Community organizations in all 5 countries have the requisite number of paid staff and volunteers to implement HIV prevention projects and advocacy activities (only Macedonia has indicated that there is a relatively small number of volunteers).

Community organizations cooperate with each other within the framework of different projects funded by international donors. There are also various platforms through which communities can cooperate with each other, or with other civil society organizations (CSOs) working on MSM and/or sexual and reproductive health and rights (SRHR) issues (SRHR platform and City Task Force through the "Cities" project in Georgia; Consortium of 3 community organizations focused on HIV — EGAL, Stronger Together, and STAR-STAR in Macedonia, etc.) Thanks to its design, ECOM's Regional Program has already helped to improve collaboration between community groups in Macedonia. The level and extent of collaboration between LGBT organizations themselves and between LGBT organizations and other HIV service organizations varies across the 5 countries and requires further improvement.

Collaboration with academic institutions is underdeveloped (with a few exceptions), as is collaboration with the private business sector. There are some examples of cooperation between LGBT groups and other KP in the target countries, however, such collaboration is not carried out consistently.

The main donor for MSM-related prevention activities and services continues to be the GFATM (in Macedonia and Belarus, it is the only donor). However, community organizations have been receiving support from other international "traditional" donors and NGOs, such as ECOM, RFSU, OSF, TGEU, MSMGF, Global Forum, etc.

There remains a gap in all 5 target countries in HIV prevention services and activities targeting trans* people. None of the organizations (community or service-provision) work on HIV prevention and other HIV-related issues among trans* people specifically. However, some community organizations work on trans* health and rights issues.

Level of Institutionalization and Quality Control of HIV Services for MSM and Trans* People

MSM populations sizes are relatively underestimated for the 5 countries and need to be updated.

More new HIV cases have been registered among MSM, however, the HIV prevalence among IDU is higher than among MSM in most countries; therefore, these countries place a greater focus on IDU in their national HIV programs. In Georgia, Kyrgyzstan, and Ukraine, there is a steady increase in HIV prevalence among MSM, with prevalence rising above 5% within this group. Some countries, like Georgia, have recorded an HIV prevalence among MSM of more than 20%. Although there has been a steady increase in HIV prevalence among MSM in the region as a whole, Armenian IBBS data shows a decrease in HIV prevalence from 2.5% in 2012 to 0.8% in 2016. In Macedonia, MSM account for approximately 80% of new HIV cases, however prevalence among this group has remained below 2%. The amount of newly recorded cases of HIV infections with a homosexual transmission route is relatively low in the 5 countries assessed, however, there are signs that such cases are underreported.

High-risk sexual behavior (both with male and female partners) increases the risk of MSM playing a large role in transmitting HIV to the general population. Sex work is also prevalent among MSM (10-14% in Belarus and Macedonia). At the same time, a large percentage of MSM are married to female partners.

There is insufficient data to generate the full cascade of HIV testing and treatment services for MSM in all 5 countries. There are two potential large gaps in the HIV testing and treatment cascade for MSM. The first is that MSM do not regularly undergo HIV testing, and when they do, HIV infection is often only detected when the infection is already quite advanced. The second gap concerns difficulties in confirming the results of those who tested positive for HIV using rapid tests. Rapid testing has been introduced in all 5 countries in recent years, and should help increase access to HIV testing. Self-testing was introduced in Belarus in September 2017. The package of prevention services is similar across all 5 countries. Preparations for piloting PrEP are underway in Georgia.

The effectiveness and cost-effectiveness of services targeting MSM have not been evaluated recently in any of the target countries. However, Optima studies were conducted in all five countries, and indicated the need to continue to provide the same level of funding (or, in the case of Macedonia, slightly increasing the funding) for HIV prevention services for MSM.

It is important to note that HIV prevention services provided by community-based organizations or by other NGOs are presently fully funded by the GFATM. Attracting national financing is a top priority for maintaining current services and ensuring their future sustainability, as the GFATM plans to withdraw from all target countries in the coming years (Macedonia is facing the earliest GFATM withdrawal, which will take place by the end of 2017). As part of the process to ensure the sustainability of services, the MoH of the target countries may want to develop standards for MSM services, based upon existing standards developed by NGOs with supportfrom the GFATM.

With respect to trans* people, there is little data on population sizes, new cases of HIV infection, or on prevention services. Belarus exhibits a good practice, in which the prevention services database allows users to indicate whether a certain client identifies as trans*. Macedonian treatment providers and community groups have reported that there are no known HIV cases among trans* people.

Optima studies show a high variation of unit cost per MSM covered, and that, in some countries, programs targeting MSM are significantly underfunded in comparison with other KP. It should be noted that data from some Optima studies is already outdated and cannot be used to assess the current situation. Although this data has changed in countries like Georgia, it continues to indicate that ensuring sustainable responses to the HIV epidemic among MSM will require additional increases in services and funding, above current levels.

Level of Participation of MSM and Trans* People in HIV Governance, Policy and Funding

In most of the target countries, MSM are explicitly mentioned in national HIV/AIDS plans and/or in equivalent documents as KP with respect to HIV transmission, prevention and treatment. The one exception is Belarus, where groups vulnerable to HIV are generally recognized, but specific KP, such as MSM, SW or IDU, are not specifically mentioned (however, Belarus' transition plan does define specific high-risk groups). Only the Kyrgyz National HIV Plan (2017) recognizes trans* people as a KP. It also mentions the population size of trans* people in the country according to programmatic data, however, no study on this has been carried out. Some country plans, such as those of Georgia and Kyrgyzstan, set specific indicators for HIV prevalence and HIV prevention and testing coverage for MSM and other KP for each year.

In all 5 target countries, LGBT communities have at least one seat in national HIV councils or CCMs. Having 1 seat and 1 vote does not necessarily result in these members having a strong influence on decision-making, but may be used to make community voices heard at the governmental level. The process of nominating and electing community representatives to CCMs is transparent and accessible by community members. However, in some countries community members are not regularly updated on CCM developments and activities. In Armenia, the CCM

representative does not represent the entire LGBT community, but rather PLH. In Macedonia, community representatives are not elected by the community itself, but rather by the NGO sector as a whole. Meanwhile, in Belarus, there is no CCM member specifically representing MSM, but rather just one that represents all communities at high risk for HIV.

All countries, with the exception of Armenia, have developed a transition plan. Armenia's transition plan is the process of being developed. All transition plans indicate the need to increase HIV treatment services and the importance of providing state funding for prevention services for MSM and trans* people (trans* people are only mentioned in the Kyrgyz transition plan). A PrEP program was initiated in Georgia thanks to the work of community organizations, the NCDCPH and the AIDS Center.

Availability and Level of Application of Government Mechanisms for Purchasing Social and Health Services from NGOs Working with MSM and LGBT Communities

In the 5 target countries, there are no official bans or restrictions on the registration and functioning of NGOs. However, in Belarus, community organizations do not indicate in their statute or registration documents that they will work on LGBT issues, and instead use more general language, as relevant government bodies have previously denied the registration of LGBT organizations.

In Kyrgyzstan, a serious threat exists that if the law against "LGBT propaganda" is enacted, the functioning and opportunity for social contracting of LGBT organizations will be made impossible.

The legislation of nearly all the countries permit buying services from NGOs on a competitive basis. However, in practice, HIV-service and LGBT organizations often have less opportunities for receiving state funding. This is because such issues are often not prioritized by the state, nor is supporting such issues politically profitable for politicians. Belarus and Kyrgyzstan are in the process of developing mechanisms for social contracting. Macedonia acknowledges that they would like to enhance existing procedures, which will require further advocacy work. In Georgia, there are rigid tendering procedures that restrict the participation of financially weak organizations (e.g. a bank guarantee is required).[33 34]

No state funds have yet been granted to NGOs or to communities for implementing HIV prevention activities among MSM and trans* people. However, in Belarus, Georgia, and Kyrgyzstan, there are successful examples of the state granting money to NGOs to work with IDU or on mental health issues.

Macedonia may serve as a best practice, as the government has revised its 2017 Annual Program on HIV to allocate specific funding for HIV prevention for the first time. In 2018, the program budget should be increased to cover the funds lost after the withdrawal of the GFATM.

General Recommendations (for All Countries)

Assessment of the Regional Program

- Repeat the assessment in 2019, while recognizing the need to retain a neutral consultant to conduct in-country interviews, and collect more independent viewpoints, particularly regarding the levels of participation of community representatives. The updated assessment should include additional questions to identify the impact made by the Regional Program.

Regional Program's Focus

Community, leadership and coalitions:

- Create common HIV/health advocacy plan for all community organizations working on HIV/health issues;
- Create a regional plan to build capacity, mentor current and new leaders of the LGBT community, and to support their HIV-related activities;
- Maximize usage of existing platforms or coalitions, such as the SRHR Platform, City Task Force, and other opportunities for collaborating with KP on budget advocacy, and issues related to stigma and discrimination;
- Strengthen the capacity of local groups to establish partnerships with academic and/or higher educational institutions, to foster collaboration and support research activities;
- Engage in active fundraising to attract new donors to support LGBT organizations working in the field of HIV and/or MSM/LGBT health in general in the country.

HIV community-based services and other HIV prevention groups

- Expand the mandate of HIV prevention work done by community organizations and activists by increasing their knowledge of HIV/health-related issues and strengthening their capacity for conducting outreach, counseling and testing. Special emphasis should be placed on the use of internet and smartphone applications in prevention interventions among MSM/LGBT;
- Provide tools, practices, and capacity building exercises to community and service-provision organizations that include trans* health and HIV prevention among trans* people as a separate agenda;
- Develop standards for prevention packages of services in each country;
- Translate WHO and UNAIDS recommendations and guidelines on standards and services targeting MSM and trans* people into national languages;
- Ensure that community organizations (working on HIV and other health issues) closely monitor and report the completion of indicators (testing, coverage by prevention services etc.) in their reports and reviews;
- Educate communities about the importance of early HIV testing and about minimizing risky behaviors among MSM.

Budget advocacy

- Initiate and actively take part in policy dialogue with state representatives to ensure the allocation of funding for prevention work among MSM in national HIV plans;
- Use the Optima tool to advocate for services and encourage the development of costing tools for prevention services for KP;
- Share experiences (best practices) of other NGOs operating in countries which have already received state funding.

Governance

- Publish bulletins or other informational documents with updates about CCM meetings on community organizations' websites and/or social media, in order to improve communication; Build the capacity of community representatives in governance bodies by mentoring them on how to effectively advocate for and raise certain issues;
- Support countries in advocating for post-GFATM governance bodies, in which LGBT community representatives are actively involved.

Recommendations for Individual Countries

Armenia

- Speed up the process of developing and approving a transition plan that includes target indicators for service coverage among MSM, and financial expenditures;
- Select the next CCM member representing the LGBT community based on the results of wide consultations and a consensus.

Belarus

- Strengthen collaboration between community organizations and NGOs working on human rights issues in general, as LGBT rights remains a sensitive issue compared to other countries, and encourage LGBT rights advocacy in the context of HIV;
- Focus efforts on improving community representation at the regional and national level of both gay and trans* people, with a focus on improving services and allocating local funding for HIV services;
- Support independent evaluation of services with a high level of involvement of local communities, using cross-city assessments.

Georgia

- Actively involve community organizations in budget advocacy processes at the city level (in Tbilisi, within the existing City Task Force);
- Advocate the state to amend tendering procedures (by removing articles/provisions on the bank guarantee requirement).

Kyrgyzstan

- Advocate for and raise funds to conduct the first population size estimation of trans* people, as trans* people are already recognized by the government as a KP;
- Increase cooperation between community organizations and other human rights organizations, international organizations, and the NGO sector in general, to advocate against the law on “LGBT propaganda”.

Macedonia

- Advocate for increased budgets for MSM in the new National AIDS Strategy and annual budgets, using historical data, the Optima studies recommendations, and epidemiological data;
- Support community system strengthening with a greater involvement of local gay men in services (delivery, quality, needs);
- Increase collaboration between HIV services and LGBT advocacy groups for joint advocacy activities, including preparation of HIV-related arguments that contribute to discussions on the need for anti-discrimination legislation and policies.

Annex. Summary by Country (Socio-economic Development)

Socio-economic Development – Armenia

	Data	Year	Source
Country populations	3,004,588	2015	http://w3.unece.org/pxweb/en/
% of males	47.73%	2015	http://w3.unece.org/pxweb/en/
% living in urban settings	62.7%	2016	http://w3.unece.org/pxweb/en/
Personal remittances (received from abroad), (% of GDP)	13.1%	2016	http://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS?locations=7E&name_desc=true
% of individuals using the internet	49.9%	2016	https://unstats.un.org/sdgs/indicators/database/?indicator=17.8.1
GDP per capita, PPP (current international $)	8,881 USD	2016	https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD
Health expenditures as % of government budget	5.4%	2016	http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD
Health expenditures as % of GDP (including private sector and out-of-pocket expenditures)	4.5%	2015	http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD
Poverty gap, based on national definition of poverty (%)	4.5%	2014	http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD Or http://data.un.org/CountryProfile.aspx?crName=GEORGIA
Press Freedom Index rating	79	2017	https://rsf.org/en/rankingë_table
Rainbow Index rating	49%	2016	http://www.ilga-europe.org/resources/rainbow-europe/rainbow-europe-2017

Socio-economic Development—Belarus

	Data	Year	Source
Country population	9,500,000	2016	National Statistical Committee of the Republic of Belarus. Number and Natural Increase of Population. Information by year. Available at: http://www.belstat.gov.by/ofitsialnaya-statistika/solialnaya-sfera/demografiya_2/g/chislennost-i-estestvennyi-prirost-naseleniya/ (06-08-2017)
% of males	46,6%	2016	National Statistical Committee of the Republic of Belarus. Number and Natural Increase of Population. Information by year. Available at: http://www.belstat.gov.by/ofitsialnaya-statistika/solialnaya-sfera/demografiya_2/g/chislennost-i-estestvennyi-prirost-naseleniya/ (06-08-2017)
% living in urban settings	77,9%	2016	National Statistical Committee of the Republic of Belarus. Number and Natural Increase of Population. Information by year. Available at: http://www.belstat.gov.by/ofitsialnaya-statistika/solialnaya-sfera/demografiya_2/g/chislennost-i-estestvennyi-prirost-naseleniya/ (06-08-2017)
Personal remittances (received from abroad), (% of GDP)	1,9%	2016	World Bank staff estimates based on IMF balance of payments data, and World Bank and OECD GDP estimates. Available at: http://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS?locations=7E&name_desc=true
% of individuals using the internet	62,23%	2015	UN database, available at: https://unstats.un.org/sdgs/indicators/database/?indicator=17.8.1 (with a link to the National Statistical Committee of the Republic of Belarus)
GDP per capita, PPP (current international $)	18,060,40	2016	World Bank, International Comparison Program database. Available at: http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD
Health expenditures as % of government budget	13,8%	2014	World Health Organization Global Health Expenditure database (see apps.who.int/nha/database for the most recent updates). Available at: http://data.worldbank.org/indicator/SH.XPD.PUBL.GX.ZS
Health expenditures as % of GDP (including private sector and out-of-pocket expenditures)	5,7%	2014	World Health Organization Global Health Expenditure database (see apps.who.int/nha/database for the most recent updates). Available at: http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

Poverty gap, based on national definition of poverty (%)	5,1%	2015	World Bank, Global Working Group on Poverty. Data collected from official government sources or calculations made by World Bank staff using national poverty lines. Available at: http://data.worldbank.org/indicator/SI.POV.NAHC
Press Freedom Index rating	153	2017	Reporters without Borders, 2017 World Press Freedom Index, available at: https://rsf.org/en/ranking
Rainbow Index rating	13%	2017	ILGA Europe. Rainbow Europe 2017. Available at: https://www.ilga-europe.org/sites/default/files/Attachments/rainbow_europe_map_2017.pdf

Socio-economic Development—Georgia

	Data	Year	Source
Country population	3,720,400	2016	http://www.geostat.ge/index.php?action=0&lang=eng
% of males	47,83%	2016	http://www.geostat.ge/cms/site_images/_files/english/Gender%20Statistics.pdf
% living in urban settings	57,21%	2016	http://www.geostat.ge/index.php?action=page&p_id=152&lang=eng
Personal remittances (received from abroad), (% of GDP)	10,45%	2015	http://data.worldbank.org/indicator/BX.TRF.PWKR.CD.DT?locations=7E-GE&name_desc=true
% of individuals using the internet	45,16%	2015	https://unstats.un.org/sdgs/indicators/database/?indicator=17.8.1
GDP per capita, PPP (current international $)	9,996	2016	https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD
Health expenditures as % of government budget	2.9% (from GDP) 8.6% (from State Budget)	2015	Moh.gov.ge http://geostat.ge/?action=page&p_id=118&lang=geo
Health expenditures as % of GDP (including private sector and out-of-pocket expenditures)	7.9%	2015	Moh.gov.ge http://geostat.ge/?action=page&p_id=118&lang=geo
Poverty gap, based on national definition of poverty (%)	21,3	2016	http://www.geostat.ge/index.php?action=page&p_id=188&lang=eng
Press Freedom Index rating	64	2017	https://rsf.org/en/ranking_table?sort=asc&order=Ranking
Rainbow Index rating	26%	2017	http://www.ilga-europe.org/sites/default/files/Attachments/rainbow_europe_index_2017.pdf

Socio-economic Development—Kyrgyzstan

	Data	Year	Source
Country population	5,950,000	2015	United Nations Economic Commission for Europe http://w3.unece.org/PXWeb/en/CountryProfile?CountryCode=417
% of males	49,5%	2015	United Nations Economic Commission for Europe http://w3.unece.org/PXWeb/en/CountryProfile?CountryCode=417
% living in urban settings	35,3%	2009	Population Census 2009. http://www.stat.kg http://www.stat.kg/media/files/d5a59588-1ad7-4c9e-952d-451f4da124cb.pdf
Personal remittances (received from abroad), (% of GDP)	30,5%	2016	World Bank staff estimates based on IMF balance of payments data, and World Bank and OECD GDP estimates, accessed at: https://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS?locations=7E&name_desc=true
% of individuals using the internet	30.3%	2015	UN SDG Indicators, accessed at: https://unstats.un.org/sdgs/indicators/database/?indicator=17.8.1
GDP per capita, PPP (current international $)	3,551.2	2016	World Bank, International Comparison Program database, accessed at: https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD
Health expenditures as % of government budget	11.9%	2014	Available at: http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD,
Health expenditures as % of GDP (including private sector and out-of-pocket expenditures)	6.5%	2014	Available at: http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD
Poverty gap, based on national definition of poverty (%)	32,1%	2014	Poverty headcount ratio at national poverty lines (% of population). Accessed at: https://data.worldbank.org/indicator/SI.POV.NAHC?locations=KG
Press Freedom Index rating	89	2017	Reporters without Borders, 2017 World Press Freedom Index, accessed at: https://rsf.org/en/ranking
Rainbow Index rating			No data

Socio-economic Development—Macedonia

	Data	Year	Sources
Country population	2,070,000	2016	State Statistical Office of the Republic of Macedonia, Statistical Yearbook of the Republic of Macedonia 2016, accessed at: http://www.stat.gov.mk/Publikacii/SG2017/03-Naselenie-Population.pdf
% of males	50%	2016	State Statistical Office of the Republic of Macedonia, Statistical Yearbook of the Republic of Macedonia 2016, accessed at http://www.stat.gov.mk/Publikacii/SG2017/03-Naselenie-Population.pdf
% living in urban settings	57%	2016	The United Nations Population Divisions World Urbanization Prospects, accessed at: http://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS?view=chart
Personal remittances (received from abroad), (% of GDP)	2.7%	2016	World Bank staff estimates based on IMF balance of payments data, and World Bank and OECD GDP estimates, accessed at: http://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS?locations=7E&name_desc=true
% of individuals using the internet	70.38%	2015	UN SDG Indicators, accessed at: https://unstats.un.org/sdgs/indicators/database/?indicator=17.8.1
GDP per capita, PPP (current international $)	15,121.3	2016	World Bank, International Comparison Program database, accessed at: http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD
Health expenditures as % of government budget	12.9%	2014	World Health Organization Global Health Expenditure database (see apps.who.int/nha/database for the most recent updates). Accessed at: http://data.worldbank.org/indicator/SH.XPD.PUBL.GX.ZS
Health expenditures as % of GDP (including private sector and out-of-pocket expenditures)	6.5%	2014	World Health Organization Global Health Expenditure database (see apps.who.int/nha/database for the most recent updates). Accessed at: http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS
Poverty gap, based on national definition of poverty (%)	22.1%	2014	Poverty headcount ratio at national poverty lines (% of population). World Bank, Global Poverty Working Group. Data are compiled from official government sources or are computed by World Bank staff using country–specific poverty lines. Accessed at: http://data.worldbank.org/indicator/SI.POV.NAHC?locations=MK

Press Freedom Index rating	111	2017	Reporters without Borders, 2017 World Press Freedom Index, accessed at: https://rsf.org/en/ranking
Rainbow Index rating	16%	2017	ILGA Europe. Rainbow Europe 2017. Accessed at: https://www.ilga-europe.org/sites/default/files/Attachments/rainbow_europe_map_2017.pdf

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